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Mental health services for Syrian refugees in Lebanon: perceptions and experiences of professionals and refugees

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Abstract

We explored the perceptions and experiences of sixty practitioners/policymakers and twenty-five Syrian participants involved in mental health services for refugees in Lebanon, using semi-structured and in-depth interviews. The results reveal that refugees view their distress as a normal shared reaction to adversity while professionals perceive it as symptoms of mental illness. Practitioners view the Syrian culture as an obstacle to provision of care, and thus prioritize educating refugees about mental health conditions. Policymakers use the emergency crisis rationale to justify short-term interventions, while Syrian refugees request community interventions and consider resettlement in a third country as the only solution to their adverse living conditions. The therapeutic relationship seems threatened by mistrust, since refugees resort to changing narratives as an adaptive mechanism in response to the humanitarian system, while professionals consider those actions manipulative. We draw on findings to suggest implications for mental health practice in humanitarian settings.

Introduction

Over one million Syrians have fled to Lebanon since the beginning of the Syrian war ([United Nations High Commissioner for Refugees UNHCR, 2019](#)). Syrians in Lebanon have restricted legal status, since the Lebanese Government denies them the official refugee status and forbids the establishment of formal refugee camps. Additionally, the Lebanese authorities introduced in 2015 restrictive policies that include closing the borders, prohibiting Syrian refugees from working, requiring them to secure a Lebanese sponsor, enforcing stringent and expensive residency regulations, and calling for the cessation of UNHCR refugee registration ([Geha & Talhouk, 2018](#); [Nassar & Stel, 2019](#)). This lack of legal and administrative framework leads to limited access to mobility, education, employment, and healthcare while rendering the situation of Syrian refugees highly precarious ([Blanchet, Fouad, & Pherali, 2016](#)).

These structural conditions in displacement settings contribute to heightened social and mental health problems ([Jayawickreme et al., 2017](#); [Killikelly, Bauer, & Maercker, 2018](#); [Li, Liddell, & Nickerson, 2016](#); [Miller & Rasmussen, 2010](#); [Ryan, Dooley, & Benson, 2008](#); [Silove, 2011](#)). In Lebanon, the vast majority of information regarding the mental health of Syrian refugees come from epidemiological studies which report a high prevalence of mental health disorders ([Karam et al., 2014](#); [Kazour et al., 2017](#); [Naja, Aoun, El Khoury, Abdallah, & Haddad, 2016](#); [Souaiby, Kazour, Zoghbi & Richa, 2016](#)). However, findings need to be carefully interpreted, since most of the tools used were not validated in the Syrian context ([Wells, Wells, & Lawsins, 2015](#)). These studies focus on symptoms of pathology, which may lead to conflating symptoms of posttraumatic stress disorder (PTSD) or clinical depression with distress related to the impact of displacement stressors ([Miller & Rasmussen, 2010](#)). Alternatively, the resource-based model of migrant adaptation frames distress as the result of obstacles to the adaptation processes. Migrant adaptation is defined as “the process through which individuals seek to satisfy their needs, pursue their goals and manage demands

encountered after relocating to a new society” (Ryan, Dooley, & Benson, 2008). The capacity to manage these demands depends on access to a range of resources and may be hindered by an adverse environment, leading to mental health problems. In line with this model, qualitative studies involving Syrian refugees emphasize that sources of emotional distress are related to ongoing displacement and include safety issues, economic strain, social isolation, loss of role and limited access to resources (Mourtada, Schlecht, & DeJong, 2017; Sim, Bowes, & Gardner, 2019; Wells, Steel, Abo-Hilal, Hassan, & Laws, 2016a).

Therefore, it is crucial to understand how Syrian refugees perceive and describe distress, since explanatory models of illness and health may explain the process of assigning meaning to health attitudes and practices (Kleinman & Benson, 2006), along with considerations of social context and power structures (Kirmayer, 2006). Studies have delineated that Syrians consider stigma to be a barrier to care, along with a lack of availability of services (Abou-Saleh & Mobayed, 2013). Explanations of distress may include belief in spirits and the evil eye, while many Syrians express emotional difficulties through metaphors that do not easily translate into symptoms of Western based diagnostic categories (Hassan et al., 2015). The crisis may have caused a shift in attitudes towards mental illness with a decrease in mental health stigma due to the shared sense of suffering and the perception of distress as a legitimate reaction to extreme life circumstances (Wells et al., 2016b).

In the specific context of Lebanon, the response of the Lebanese humanitarian workers to the refugees’ distress may be challenged by the sociopolitical history between the two countries (Sahab, Khoury, El Hussein, & Moro, 2018). The prolonged presence of Syrians in the country has awakened painful memories of the 1991 to 2005 Syrian occupation of Lebanon and of the Palestinian refugees settlement since 1948 that led to militias springing up in the camps (Geisser, 2013). Several non-governmental organizations (NGOs) have reported rising tension between Syrian and Lebanese host communities due to the perception of unfair support

from the international community to Syrian refugees compared to poor Lebanese communities (Care International, 2018). Public opinion is further fueled by the discourse of Lebanese politicians framing refugees as the cause of unemployment, instability and diseases (Geha & Talhouk, 2018). The establishment of trust in the therapeutic relationship between Lebanese professionals and Syrian patients may be challenged by this context since practitioners are equally subject to the political climate as any other member of society (Spangler, Thompson, Vivino, & Wolf, 2017). Exploring the challenges to a therapeutic alliance in this context is crucial given that the most consistent predictor of outcome in psychotherapy is the quality of the client-therapist relationship (Lambert, 2013).

Overview of mental health services for Syrian refugees in Lebanon

Similar to the wider health care system in Lebanon, mental health services are divided between a poorly resourced public sector and a highly expensive private sector (Kerbage, 2017). Mental health and psychosocial support services (MHPSS) for Syrian refugees are mostly provided by local and international NGOs to supplement the existing services. These NGOs work in close coordination with the Lebanese Ministry of Public Health (MOPH), so that primary health care centers can ensure the continuity of care once the NGO program has ended. Accordingly, the MOPH recently developed a MHPSS task force, co-chaired by the World Health Organization (WHO) and the United Nations Children's Fund. This task force aims to implement “cost-effective and evidence based mental health interventions and to coordinate the work of all MHPSS humanitarian actors involved in responding to the Syrian crisis” (Karam et al., 2016).

The MHPSS framework for Syrian refugees in Lebanon is based on the Inter Agency Standing Committee (IASC) guidelines on MHPSS in emergency settings (IASC, 2007), that recommend organizing the mental health response according to a pyramid of interventions. This pyramid constitutes a layered system of complementary support starting with basic

services and security at the community level (level 1), followed by strengthening family and community support (level 2), individual psychosocial support (level 3) up to specialized clinical services (level 4). Within this framework, the term psychosocial is coined to describe the general support of wellbeing as well as non specialized interventions for people with mental conditions (IASC, 2007). Hence, the guidelines stress meeting the needs at a community level before reaching the specialized level (Van Ommeren, Saxena, & Saraceno, 2005; IASC, 2007). Humanitarian organizations rely on the IASC pyramid following international consensus over the efficiency of this framework for mental health services in crisis settings (Van Ommeren, Saxena, & Saraceno, 2005; Silove, 2011). Figure 1 shows the distribution of MHPSS activities in Lebanon by level of the IASC Pyramid of Services according to a service mapping published by the MOPH (Kheir, Gibson, Kik, Hajal, & El Chammay, 2015), showing that half of the services are situated at level 3.

Figure 1: Distribution of MHPSS activities by level of the IASC Pyramid of Services in 2013 and 2014, according to a mapping of services by the MOPH, adapted with permission (Kheir, Gibson, Kik, Hajal, & El Chammay, 2015)



In this study, we explored the perceptions and experiences of policymakers, practitioners and Syrians involved in mental health services at the individual focused levels of the IASC pyramid, including level 3 (non specialized psychosocial support provided by social workers) and level 4 (specialized services provided by psychotherapists and psychiatrists). We chose individual focused levels to study the therapeutic relationship in a clinical setting and understand the mental health problems of Syrians that are deemed severe enough to warrant an individual based intervention rather than a community service. We drew on in-depth interviews with Syrian refugees to study their perceived sources of distress and support, as well as explanations of and attitudes towards their mental health problems. In light of the resource based model framework, we examined how adaptive processes are impeded and thus lead to distress warranting a mental health service. We simultaneously explored the experiences of professionals, both at the service providing level (social workers, psychotherapists, psychiatrists), and the intervention design and implementation level (policymakers and program coordinators). We triangulated multiple data sources in order to develop a comprehensive understanding of the Syrians' mental health problems ([Patton, 1999](#)).

Method

Participants' recruitment

Data collection was carried out from April 2016 to March 2017. Participants were recruited following a purposive sampling constructed to specifically target Lebanese professionals involved in mental health services providing both individual psychosocial support (level 3) and clinical services (level 4), as well as Syrians using those services.

Recruitment of professionals: Ten NGOs were found to provide mental health services at both levels 3 and 4 of the IASC pyramid, based on a service mapping published by the MOPH ([Kheir, Gibson, Kik, Hajal, & El Chammay, 2015](#)). We recruited from each NGO, up to three social workers (out of a pool of five to ten depending on each NGO), up to two

psychotherapists (pool of five to six), one psychiatrist (pool of two to four), and the program coordinator. The recruitment process was preceded by a visit to each NGO main office during which we met with the available staff and explained the aims and procedures of the study. Persons who voluntarily accepted to participate were later contacted to schedule an appointment for the interview. Three other persons were purposefully contacted and interviewed because of their role in the design and implementation of mental health interventions at a national level: a policymaker as well as a psychologist from the MHPSS-Task Force/MOPH; and a national WHO representative. In total, 60 Lebanese professionals were interviewed.

Recruitment of Syrian refugees: Among the ten NGOs we approached, only two granted us access to Syrians using their services. These were international NGOs, based in the Bekaa and Beirut regions. The inclusion criteria for Syrian refugees included being between 18 and 64 years old, and using the services on regular basis for a period exceeding three months, to ensure a sufficient time frame of their experience with the service to provide us with their feedback. The youth and elderly were excluded as we considered that they have distinct needs and sources of distress ([Chemali, Borba, Johnson, Khair, & Fricchione, 2018](#); [Mourtada, Schlecht, & DeJong, 2017](#)). The exclusion criteria included the presence of psychosis, bipolar disorder, intellectual disability, or a current severe mood episode, based on the NGO psychiatrist's evaluation. At the time of the recruitment, the researchers explained the aim and procedures of the study after being introduced to the refugees by the social workers. Our final sample included twenty-five Syrians who met the inclusion criteria and voluntarily consented to participate.

Study design

We used semi-structured and in-depth interviews to capture subjective experiences and

meanings around distress, wellbeing and mental health interventions, based on the explanatory model approach to illness and health (Kleinman & Benson, 2006). We decided against focus groups as this method could have discouraged participants from freely expressing views, in a context where security concerns limit information sharing (Diggle et al., 2017).

Interviews with professionals: Hala Kerbage conducted one semi-structured interview with each Lebanese professional, averaging sixty minutes in length, in a private room at the NGO's headquarters or in the policymaker's office. The semi-structured format allowed us to focus on our initial research interests while enabling a conversational style with its set of interactional dynamics (Marvasti, 2010; Morse, 2012). We developed an interview guide in consultation with academics and NGO workers as detailed in Figure 2. It was piloted with a small group of participants and refined based on their feedback. The main revision was to section 4 that explored perceived challenges since the pilot revealed it to be a sensitive topic for professionals who felt uncomfortable discussing specific difficulties, as this could have signified the program's ineffectiveness or due to their personal stake in the program. Therefore, the questions were kept as broad as possible. The interview guide was adapted depending on whether the participant was a policymaker or a practitioner. The questions about the NGO's program (section 2) were more general for the three policymakers interviewed and were not specific to one organization. They revolved instead around the role of individual focused services (levels 3 and 4 of the IASC pyramid) within the general MHPSS framework and the rationale behind the choice of the interventions.

Figure 2. Interview Guide for Practitioners and Policymakers

1. Exploring their position in regards to the organization:

- Can you describe your responsibilities within the organization?

2. Exploring the MHPSS program of the organization:

- Please describe the mental health program in place at your organization.

- Please describe how refugees access your services.
- Please describe the psychosocial interventions provided by your organization (level 3).
- What type of psychotherapies does your organization provide? (level 4)
- How is the referral to the psychiatrist made? (level 4)
- Can you describe the coordination process with other MHPSS organizations?
- Why do you think the organization chose to implement those interventions?
- What do you think of those interventions?

3. Exploring the perceptions of the Syrians' mental health problems:

- Please describe the mental health problems faced by Syrian refugees.
- What do you think are the main causes of their distress?
- How do you feel they cope with these problems?
- What do you think are their main psychosocial and mental health needs?
- What do you think refugees expect from the MHPSS service?
- Can you give me one example of a case that particularly marked your experience?

4. Exploring the main challenges experienced in their practice:

What are the main challenges that you face while working with Syrian refugees?

Interviews with Syrian Refugees: During an initial meeting at the NGO office, each participant was asked to suggest a suitable time and location for interviews. All participants chose to be interviewed at their houses. Filippo Marranconi carried out three separate in-depth interviews, each averaging ninety minutes, with each of the twenty-five Syrian participants. Hala Kerbage or Yara Chamoun accompanied him whenever the Syrian participant was a woman to match cultural gender sensitivities, engaging in the interview when necessary. Interviews were unstructured and open-ended in style (Marvasti, 2010; Morse, 2012). Initially, the interviewer simply invited refugees to share their story, by asking the following opening question: “Can you tell me about your life in Lebanon?” Participants determined the flow of information although when necessary, interviewers sought additional information, based on previously developed probes or within the natural flow of conversation. For example, when participants broached interesting subjects minimal probes were used to assist them to continue such as “Can you tell me more about this?”, “Can you give me an example?”, and “How did you feel about that?” (Johnson, 2001). An interview guide was designed to cover three aspects of life for Syrian refugees in Lebanon as detailed in Figure 3: The Syrians’ perceived sources of distress and support, explanations of and attitudes towards mental health problems, and their experiences with MHPSS services. We interviewed Syrian participants over several meetings to allow time for each topic to be fully discussed.

Figure 3. List of questions explored during in-depth interviews with refugees

Opening question: Can you tell me about your life in Lebanon?

1. Exploring the Syrians’ perceived sources of distress and support

- Can you describe the main problems you are facing in Lebanon?
- How do you usually deal with these problems?

2. Exploring the Syrians’ explanations of and attitudes towards mental health problems (Kleinman & Benson, 2006)

- Do you feel you suffer from a mental health problem? Can you describe it?
- What do you call this problem?
- What do you believe is the cause of this problem?

- What course do you expect it to take and how does it affect your body and mind?

3. Exploring the Syrians' experiences with MHPSS services

- How did you access the mental health service?
- Can you describe what type of interventions was provided for you?
- What do you think of these interventions?
- What do you feel would be beneficial for your wellbeing?

In-depth interviews were done at the refugees' homes or tents allowing for informal conversations and coffee breaks. This setting helped build a trusting relationship with participants while mitigating the risk of power disparities (Hynes, 2003). The in-depth interviewing technique ensured the gathering of authentic data by delving into the subjects' deeper self and gaining an empathic appreciation of their reality (Johnson, 2001). In order to ensure consistency between interviews, an interview protocol was developed, detailing the method to begin and end the interview, and post interview requirements (check audiotape for clarity, summarize key information, and transcribe the interview within 24 hours). In both types of interviews, questions were used to guide rather than dictate the course of the interview (Marvasti, 2010). Participants were viewed as experiential experts and any novel areas of inquiry they mentioned were followed up.

All interviews were carried out in Arabic. Hala Kerbage and Yara Chamoun are native Lebanese Arabic speakers while Filippo Marranconi is a fluent Syrian Arabic speaker. As Syrian and Lebanese Arabic are similar dialects from the same regional Arabic dialect group - the Levantine group – the risks of linguistic misunderstandings were minimized. Interviews were audio-recorded following participants' consent.

Ethics

This study was granted ethical clearance by Saint-Joseph University Ethics Board in Beirut, Lebanon. Most Syrian refugees were reluctant to sign the written consent form, despite their desire to share their experiences. They expressed that providing a signature was a source

of anxiety as it evoked a legal implication. After consultation with the ethics committee, it was decided that the researchers would sign the consent form in the presence of a witness to testify that participants gave verbal consent to the study. This alternative was well received by Syrian refugees. Professionals gave written consent to the study. All data were made anonymous and recordings were destroyed following analysis.

Since interviews with refugees took place at their homes, it was challenging at times to ensure privacy in overcrowded housing. This obstacle was overcome as some participants indicated preferred time for interviews, or by going for walks around the neighborhood. Other participants, however, did not feel at all limited by the presence of family or community members and insisted on talking in front of them, involving them as witnesses to confirm information. We therefore adapted to the participants' comfort and let them establish the interview setting. Previous research has shown that in some indigenous contexts the Euro-American ethical codes for informed consent and confidentiality may not always make sense for community-centered social groups ([Zaman & Nahar, 2011](#)). Therefore, we tried to combine acting ethically with responding culturally to different conceptions of privacy.

There was no financial compensation for participation in the study. Refreshments were offered during interviews with Syrian refugees. All participants were given the contact information of the research team in case they had questions after the interviews. When participants showed signs of emotional distress while talking about sensitive issues (e.g. sexual harassment), the researchers, with the participants' consent, contacted the social worker assigned to their case at the NGO to arrange a follow-up. This happened with only one participant, as we excluded Syrian refugees who were suffering from a severe mood episode and also due to the regular mental health follow-ups at the NGO provided for the participants at the time of the study. The study's findings were presented at a symposium organized by one of the NGOs that allowed us access to Syrian refugees, in the presence of UNHCR and MOPH

representatives.

Data analysis

Interviews were transcribed verbatim by the researchers who conducted them. The other researchers listened to the recording and checked the transcription. Filippo Marraconi translated selected quotes to English. Native Arabic speakers in the research team verified the translations. Preliminary data analysis and data collection were conducted concurrently, allowing us to cease recruitment on achieving coding saturation, that combined inductive thematic saturation, related to the emergence of new codes at the level of analysis, and data saturation, related to the degree to which new data repeat what was expressed in previous data, at the level of data collection (Saunders et al, 2018). We approached saturation as an ongoing judgment rather than something that can be pinpointed at a specific juncture. However, after several interviews, there were diminishing returns from further data collection and we were confident of having closely approached coding saturation.

Semi-structured interviews, in-depth interviews, and field notes were linked in a triangulated strategy. Thematic analysis methods were used to allow for themes and patterns to emerge from the triangulated data (Morse, 2012). Data were compiled, disassembled and reassembled, following a multistage recursive coding process (Braun & Clarke, 2006; Morse, 2012). Following repeated data immersion to gain analytic insight of the data, Hala Kerbage and Filippo Marraconi inductively coded the transcripts separately. Coding was redone as a group, including authors who were not involved in conducting the interviews, in order to reach consensus regarding the coding discrepancies and refine the codes. No software was used. The framework for this study was developed using a bottom-up approach based on key themes emerging from the data (Braun and Clarke, 2006). Emergent themes from the analysis of professionals' interviews were classified in relation to the professionals' perceptions regarding the Syrians' in general, their mental health, the rationale behind interventions provided, and

the challenges encountered in their work. Themes from the analysis of Syrians' interviews were classified in relation to the Syrians' perceived sources of distress, adaptive mechanisms, explanations of and attitudes towards mental health problems and perceptions of services. Checking on the emergent themes was conducted by asking two Syrian participants for feedback, as well as three Lebanese practitioners. Relevant suggestions were incorporated into the results. The quotes presented in the results section are illustrative of specific codes included in our themes.

Results

Sample characteristics

All professionals interviewed were Lebanese nationals. All service providers had more than two years of experience at the NGO and their ages ranged between 24 and 39. Table 1 below shows the gender distribution among types of practitioners interviewed.

Table 1. Gender distribution among types of practitioners interviewed.

	Social workers	Psychotherapists	Psychiatrists	Program coordinators	Policymakers	Total
Females	20	13	2	6	1	42
Males	0	4	8	4	2	18
Total	20	17	10	10	3	60

The Syrian participants' ages ranged between 24 and 46 years old and they originated from different regions of Syria. The age range and higher proportion of women among participants represents the population of refugees most likely to use MHPSS services, according to the two NGOs' records. All participants were married with children. Refugees from Beirut (10 participants) lived in rented apartments shared with other Syrian families; the ones from Bekaa (15 participants) lived in informal refugee settlements (tents or shacks). Table 2 shows the Syrian participants' educational attainment by gender.

Table 2: Education level of Syrian participants by gender.

	Females	Males	Total
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Graduate degree	3	0	3
Undergraduates	4	1	5
High school	4	2	6
Complementary school	1	2	3
Primary school	6	2	8
Total	18	7	25

At the time of the study, all 25 Syrian participants received individual psychosocial support by a social worker (level 3 of the IASC pyramid) consisting of informal counseling once a week, awareness sessions and regular home visits, according to the social workers' description. Among them, 16 were additionally receiving supportive psychotherapy sessions, centered on providing emotional support and developing coping skills, based on the psychotherapists' description. Ten participants were also seen by a psychiatrist once a month and took antidepressant medications for depression, anxiety disorder and/or posttraumatic stress disorder; they were considered to be in remission according to the psychiatrist's evaluation. The psychiatric care consisted of regular sessions with a psychiatrist to detect and monitor symptoms of psychiatric conditions based on international classifications.

In the following section, we present the most recurrent themes and sub-themes that emerged from our inductive analysis of the perceptions of professionals and refugees.

Professionals' perceptions

Professionals in our study are divided into two categories: 47 service providers (social workers, psychotherapists, psychiatrists) working in the field with refugees, and 13 policymakers/program coordinators working at the level of conceptualizing and implementing mental health programs at the national level (3 policymakers) or at the NGO level (10 program coordinators). The three themes below were common to both categories, however, one theme that emerged was exclusively from the policymakers/program coordinators' interviews as highlighted in a separate section (theme 4).

Theme 1: The Syrian culture constitutes an obstacle to mental health care provision.

Among professionals, 56 out of 60 repeatedly highlighted the Syrian culture as the main challenge to working with Syrian refugees. They considered it an obstacle to the efficient provision of mental health services. When mentioning culture, professionals used the word in English or in French. Alternatives in Arabic (حضارة, ثقافة) were not found in the transcripts. Sometimes professionals used the word بيئة when talking about culture, to which the exact translation in English is environment.

Illiteracy and lack of education are features of the Syrian culture.

Professionals complained about the high level of illiteracy and lack of education among refugees and described it as a cultural trait of the Syrian population. Even though they recognized the refugees' economic difficulties, most of the professionals attributed the high rate of school dropouts among Syrian children to a “cultural” lack of interest in formal education. Professionals interpreted many of the Syrians' behaviors in general – such as high birth rates - as being consequences of lack of education. For example, 32 professionals described the high birth rate among this population as “an irrational, illogical and uneducated way” of dealing with adverse life conditions.

“Illiteracy is very common among Syrians...it is in their culture... you see a lot of ignorance...for example, cousins marry each other, children drop out of school early, they keep having children although they have no means to provide for them...how do you explain that!” Social worker

“Syrians are ignorant, they are not educated...it is a cultural trait...” Psychiatrist

The Syrian culture is “traditional” in contrast to the “modern” psychiatric language.

The Syrian refugees' behaviors are interpreted through their “traditional culture” that impedes “modernity”. Illiteracy - viewed as a cultural trait - is described as a factor fostering resistance to mental health treatment. The Syrian “culture” prevents them from understanding

the “modern” psychiatric language and from following the professionals’ instructions (for prescriptions or psychotherapy).

“You have to explain to them over and over again how to take the medications, what psychotherapy is about, why they should come to the sessions...They don’t have the culture for mental health [...] they are very traditional, they don’t see the need for all this...they are mainly concerned about material things.” Social worker

“They are traditional, it is their culture [...] they don’t understand the progress of medicine and psychiatry, what the medication or the psychotherapy can do.” Psychotherapist

“Culture is a main obstacle because the Syrian culture is very traditional so if you want to implement mental health programs, they will not understand its importance.” Program coordinator

Theme 2: MHPSS interventions are a means to educate Syrian refugees about mental health disorders.

Among professionals, 45 out of 60 considered awareness sessions and education about psychiatric knowledge as an adequate response to the “ignorance of Syrians due to their culture” and viewed them as part of the psychosocial support interventions at level 3, provided by non-specialized staff (social workers).

“Convincing” refugees of the necessity of the service is a core feature of mental health education (تقنية).

“They say: I am very tired, I am nervous, I can’t stand my children...they don’t say: I am depressed. They don’t know they are, but we know it...we know the symptoms, we educate them about depression, PTSD, that these are diseases like any others...You have to convince them that they need mental health services as they don’t consider it a priority.” Social worker

This social worker, like many other practitioners, emphasized the lack of education of Syrian refugees about mental health disorders. Awareness sessions are therefore perceived as means to recruit patients for specialized MHPSS services, since Syrians will not independently seek a mental health service:

“You have to go search for them...they will not come by themselves and say: I need a psychiatrist the way they would say I need a primary health care physician...We have to convince them that they need the service. You have to tell them that taking medications will help them but you have to try hard before they accept, because they don't consider it a priority, they want a job, material aids, but we tell them we cannot help them materially but psychologically.” Social worker

The social workers reported that awareness sessions usually take place in the waiting rooms of primary health care centers attended by Syrian refugees. They added that sometimes, awareness sessions include visits from the social workers to the informal refugee settlements, in the form of “outreach visits”, where they introduce themselves to the people and explain that they are trying to determine if refugees are in need of mental health services. According to social workers, they ask specific questions about symptoms of depression, PTSD, psychosis and other diagnostic categories, and distribute informational brochures about the various disorders. For example, they ask the following questions to screen for depression: “Are you sleeping well? Are you eating well? Are you sad most of the times? Do you feel you can't enjoy anything anymore?” When refugees answer affirmatively, the social workers explain that they might have a psychiatric condition, and that they would benefit from a mental health service. The social workers interviewed repeatedly used the word “convince” (in Arabic, إقناع, which has no alternative meaning) when describing how they persuaded refugees to accept consulting a psychotherapist or a psychiatrist.

Mental health disorders are presented as similar to any other medical disorders.

One of the most frequent methods to convince refugees, other than describing the symptoms, was to compare mental disorders to any other medical condition:

“You have to explain to them that there is nothing to be ashamed of, that this is a disease like any other. Depression, for example, is one of the most frequent illnesses in the world...sometimes I tell them suppose you have diabetes or hypertension, wouldn't you take a medication? Why should depression or psychosis be any different?” Social worker

“We coordinated trainings on the Mental Health Gap Action Program (mhGAP) to social workers

so that they can detect mental health conditions among refugees and educate them about it, especially about the fact that these are medical conditions that need treatment” National Policymaker

The mhGAP is a guide elaborated by the WHO to allow non-specialists to detect mental health conditions and increase the availability of mental health treatments in primary care (WHO, 2016). It was mentioned repeatedly in our study as an efficient tool for social workers at a non-specialized level (level 3) allowing them to screen for mental health conditions and organize the referral accordingly to clinical services (level 4). Most professionals (21 out of 47 service providers, 6 out of 10 program coordinators and all three policymakers), considered the mhGAP to be an important component of the psychosocial support at the level 3 of the IASC pyramid.

A minority considers that psychiatric referrals are being done before addressing basic needs.

Some professionals had a different perspective regarding refugees’ needs. They interpreted the Syrians’ lack of interest in psychotherapy or medications as a consequence of being preoccupied with fulfilling basic needs for survival, rather than a lack of education. Among psychiatrists, three out of ten complained that psychiatric referral was premature.

“Sometimes the social worker would refer a refugee saying that he suffers from PTSD. Most of the time I discover that he does not have PTSD...he has Rent Stress Disorder [Laughs] These people are more concerned about how to pay their rent than anything else [...] Many Syrian women ask me to write reports stating they need diapers...So, I write: “This is to certify that Mrs. X is in urgent need of diapers for her children as this will tremendously affect her mental health.” I swear I wrote this report once to UNHCR...and she got the diapers! Is this what psychiatry is about? After that all the refugees wanted an appointment with me! [Laughs] [...] I often tell the social workers they refer patients to me too early...” Psychiatrist

Theme 3: The refugees' "lying" is a threat to the therapeutic relationship.

Many professionals (33 out of 60) mentioned the difficulties of establishing a therapeutic alliance with Syrian refugees, because of their fear of being manipulated. In some cases they related this problem to the refugees' tendency to lie to them.

Refugees lie in order to obtain material benefits.

« Liars...you can say they are liars... There are some people who manipulate you... It happened to me once that a woman told me: "If you don't help us, I'm going to convince my husband to fight with the Islamic State!" Madam, I'm a psychologist, I can't offer you material help! And you know, they already receive aid, every month...but they continue to ask...» Psychotherapist

"During staff meetings, practitioners often complain about refugees lying [...] I think refugees lie in the hope of having more aids [...]" Program coordinator

Most professionals complained that refugees constantly asked for reports stating they suffer from a psychological condition that needs specialized treatment abroad, hoping this would influence the UNHCR decision in selecting them for resettlement. They also complained that Syrians repeatedly asked about material aids in therapeutic settings.

Refugees' lies are related to a manipulative character.

Lying is perceived by professionals as a personal affront, or the feature of a manipulative character, in contrast to their own humanitarian attitude seen as moral per se and, therefore, legitimate. Some expressed their profound frustration regarding the purpose of their work and the crisis of their role as therapists:

«Once a woman came back to the clinic after a long absence; she told me she went to the UNHCR – she's anxiously waiting to travel, she's obsessed with this: she wears her cell phone earbuds at all times, because she's afraid of missing UNHCR's call - they told her a group had just been accepted for resettlement to Germany, but that she was not part of it. She started telling me they were liars...she took off her veil and started beating herself, saying she wanted to commit suicide [...] Sometimes I get angry because I feel manipulated... » Psychotherapist

Theme 4: MHPSS interventions should be short-term and evidence based because it is an emergency crisis.

All three policymakers and a majority of program coordinators (6 out of 10) referenced the emergency crisis rationale as a determinant factor in the choice of the types of interventions provided.

Ideal MHPSS interventions are clinical, time-limited and evidence based.

“MHPSS services should be time-limited, or else, Syrians will become dependent on the services...after all, it is an emergency crisis. Services should not be offered for more than three months to each beneficiary [...] The MOPH is training primary health care staff to screen and treat mental health disorders so they should be able to do the job too...at a clinical level, we need structured and time limited interventions like Inter-Personal Therapy (IPT) or Eye-Movement Desensitization Reprocessing Therapy (EMDR) ...” Program coordinator, International NGO

Policymakers also stressed the importance of choosing interventions that are evidence based, and focused on clinical services (level 4) rather than psychosocial interventions (level 3) that were viewed as lacking the necessary evidence: “there is no consensus about what a psychosocial activity is”; “it is an umbrella term for a wide range of activities”; “we have no way to measure its efficacy”.

“In this context of acute emergency crisis, we need to promote brief evidence-based therapies like IPT, EMDR, or Trauma Focused Cognitive Behavioral Therapy, ideally for six or twelve sessions. We are training NGO staff (psychotherapists) with the help of an American university on these approaches to try homogenizing the services [...] IPT has been tested successfully by Bolton¹ in a refugee setting in Uganda in a randomized controlled trial so we think we can implement it here too...EMDR and Trauma Focused Therapy have some evidence for treating PTSD...” MOPH representative

“ I am not aware of any psychosocial intervention that is evidence based yet...but clinical

¹ The interviewee is referring here to the study by Bolton et al., 2003.

approaches in refugee settings have been tested in randomized controlled trials” MOPH representative

Service providers perceive the emergency crisis rationale as an obstacle to their work.

Service providers, especially social workers, disagreed with the importance of the emergency crisis rationale and described the contradictory nature of their work. On one hand, they are required to “convince” the refugees about the need of a mental health service and promote their care engagement through regular phone calls. On the other hand, they must cease the services after a limited timeframe, usually three months.

“It was heartbreaking having to call all these people and tell them we would no longer see them. The same people we recruited and worked so hard to convince of their need for services...And from one day to the other, we had to stop seeing them...and tell them they should go to the primary health care center from now on [...] sometimes I lose the sense of purpose and continuity in what we do with this population...” Social worker

Other problems, mainly the inconsistency in funds that would make the NGO abruptly stop a service, or the shortage in medications supply were also considered to be related to the emergency crisis rationale.

The professionals’ perceptions are summarized in Table 3:

Table 3. Emergent themes and sub-themes extracted from the interviews with professionals

Themes	Sub-themes	Frequency
1. The Syrian culture constitutes an obstacle to mental health care provision.	<ul style="list-style-type: none">- Illiteracy and lack of education are features of the Syrian culture.- The Syrian culture is “traditional” in contrast to the “modern” psychiatric language.	56 out of 60 professionals (93%)

2. MHPSS interventions are a means to educate Syrian refugees about mental health disorders.	<ul style="list-style-type: none"> - “Convincing” refugees of the need for the service is a core feature of mental health education (إقناع). - Mental health disorders are presented as similar to any other medical disorders (using the mhGAP) - A minority perceives referral to the psychiatrist as being done before addressing basic needs. 	<ul style="list-style-type: none"> - 45 out of 60 professionals (75%) - 3 out of 60 (5%)
3. Refugees’ “lying” is a threat to the therapeutic relationship.	<ul style="list-style-type: none"> - Refugees lie in order to obtain material benefits. - Refugees’ lies are related to a manipulative character. 	33 out 60 professionals (55%)
4. MHPSS interventions should be short term because it is an emergency crisis.	<ul style="list-style-type: none"> - Ideal MHPSS interventions are clinical, time-limited and evidence based (IPT, EMDR and Trauma-Focused Therapy). - Other professionals perceive the emergency crisis rationale as an obstacle to their work. 	<ul style="list-style-type: none"> - All three policymakers and 6 out of 10 NGO program coordinators. - 24 out of 60 (40%)

Syrian refugees’ perceptions

Theme 1: Environmental and psychosocial stressors are the main causes of emotional distress.

All Syrian participants reported a high level of environmental and psychosocial stressors and considered them their main source of distress.

Environmental and structural stressors:

The most prominent theme was the lack of fulfillment of basic needs, including: difficulty paying rent, poor housing, overcrowding, unemployment, being exploited at work, complicated registration procedures and lack of information about available services that limited access to

health care and education for their children. Nearly half of them reported experiencing discrimination from the host community, with reports of physical assaults or insults by Lebanese people in their neighborhood and bullying of their children at school. Among women, thirteen out of eighteen participants spontaneously revealed having been the victims of sexual harassment. All participants reported movement restriction and feared random arrests by the police. All of the refugees interviewed expressed that their most urgent concern was adapting to these adverse living conditions in displacement.

“What is gone is gone...My house, my shop, everything I owned, all destroyed in the war...But these things are in the hands of God... All I can think about now is how to survive here. Will I be able to pay my rent at the end of the month, will I find myself on the streets with my family? These thoughts keep me awake at night [...]” A 35-year- old father of three

Psychosocial stressors:

Syrian participants described the loss of a social and occupational role as a major stressor. The inability to financially provide for their family frustrated and distressed men, while some women experienced a shift in responsibilities as they became the main provider. The reversal of traditional gender roles created tension in the family. Specifically, the inactivity of men increased stress and led to marital conflict, while the inactivity of children increased children’s behavioral problems and led to parental harshness.

“I became irritable, I never was before...I can’t help but beat my children sometimes, I have no other way to discipline them. I feel bad about it, I know it is not their fault [...] My husband has become so nervous, he is at home all day and yells at me. So I become irritable with the children because I don’t want to argue with my husband...” A 32-year-old mother of two

All Syrian participants reported a loss of social networks, social isolation, and worries about family members still in Syria or who have gone missing.

The perceived lack of assistance from aid agencies:

Another common source of distress reported by participants was the lack of

humanitarian assistance to help with basic needs, and the perception of favoritism among aid agencies. Participants expressed anger at not being deemed eligible to receive aid and wondered about what would it take to be eligible. They felt humiliated by the treatment of aid agencies and the lack of transparency regarding aid distribution:

“We never know when the UNHCR will cut our monthly aid of cash assistance...Sometimes it is stopped abruptly for several months then it comes back...We don’t know what we did or didn’t do in order to be judged eligible for material assistance...This is so frustrating...I can understand those women who threaten to immolate themselves in front of the UN building...I wouldn’t do it, because of my children, but sometimes I feel this is the only way to be heard...” A 38-year-old mother of four

Theme 2. Mental health symptoms are a normal and collective reaction to a build-up of pressure (ضغط)

Participants in our study did not feel ashamed of attending a mental health service; they attributed their emotional distress to adverse living conditions and saw it as a normal reaction to their situation. They described it as a collective experience since “everyone is tired”; “we are all living the same conditions”. They did not perceive themselves as suffering from mental illness, which they viewed as being an internal dysfunction within the person, or “craziness” (إضطراب, جنون). Rather, they perceived their mental health problems as being the result of external stress. The equivalent word in Arabic - “daght ضغط” - describes not only stress but external tension that exerts a pressure on the person. This metaphor of “pressure” was reported by all Syrian participants.

Perceived symptoms of emotional distress

All of them experienced symptoms of emotional distress, and described it as anger غضب, frustration إحباط, hopelessness أمل في ما, inability to imagine a future ما مستقبل, fear خوف, exhaustion إرهاق, fatigue تعب and loss of dignity كرامة في ما. They also reported chest pain (عبرة)

and physical symptoms described by the metaphor of being strangled (خنقة). They did not consider their symptoms to be consequences of a mental illness and viewed them as common to all Syrians in displacement.

“It was the first time I ever attended a mental health service...the doctor told me I had depression. I am going through hard times, with my husband dead, having to take care of four children alone, so it is normal to feel sad [...] She prescribed some medication, said it would help me feel better. I don’t mind taking it but it is not going to change my reality...I know I am not ill... I am just tired...like all the Syrian people here...we have a lot of pressure ضغط because of how we live here...” A 40- year-old Syrian widow

“It is not only us, it is all the Syrian people, so we have to say thank God we are still alive...and do our best to survive...There is an Arab proverb that says: when it is shared, it is less of a burden (لما خفت عمت)” A 35-year-old father of three

“The social worker told me I should see the psychiatrist, because I fear going out of my house, my heart races so fast when I see a checkpoint...The doctor told me I have some disorder called “symptoms after a shock” (الصدمة بعد ما عوارض); *the participant was referring to PTSD*). She was trying to help, but I didn’t feel she got it...She kept telling me that because I was arrested once in Syria, it caused a shock so I am avoiding going out of my house. I told her: “With all due respect doctor, I barely go out of my house because I don’t have a residency permit, I can’t afford getting it, and if I am arrested here, what will happen to my family?”[...] I feel so angry, and hopeless [...] I still took the medication she gave me...after all, why not? It helped me sleep and decreased the heart racing...but I am not convinced I have a disorder ...” A 36-year-old father of two

“I was referred to the psychiatrist by the social worker. When I asked her why, she said: “You have been here for four years, you should have adapted by now! Maybe you are suffering from depression that is preventing you from adapting.” I mean, how can you really adapt to such circumstances? Still, I went. I thought the medications would help me become less short-tempered with my children, but I know deep down that if I had a better situation, I wouldn’t need any medication...” A 37-year-old mother of three

MHPSS services are perceived as a source of support and a potential link to UNHCR.

Syrian participants perceived MHPSS services in general as a safe and friendly space where they could discuss their problems, rather than a specialized clinic. They mentioned specifically the informal support from social workers as well as home visits as being helpful.

“The social worker, the psychologist (*referred to by their names*) are my friends, my sisters...I love when they come visit me at home. I feel like someone cares about me [...] Once I was harassed by a taxi driver; I immediately called the social worker and she comforted me, told me it was not my fault, that we can practice some protective strategies to prevent this from happening again...” A 38-year-old mother of three

MHPSS services were also perceived by Syrian refugees as a potential link to the UNHCR, that can advocate for their case or help them get resettlement in a third country.

Theme 3. Resettlement is the only “true and definite” solution beyond the perceived need of psychosocial interventions.

Syrians in our study considered resettlement in a third country to be the only definite solution to their social and mental health problems.

Resettlement is considered the only hope.

All participants saw resettlement in a third country as the only outcome that granted them a future: “If I am accepted, I will immediately feel better, I wouldn’t need any medication”; “My only hope is to be accepted in a developed country where our rights are respected”; “All my fatigue and frustration will disappear if the UNHCR lets me travel”; “There is no future for my children unless we travel”. They all reported being in a temporary situation, awaiting a call from the UNHCR that would “save” them. The countries mentioned were Canada, Australia, Sweden, Germany, France, Italy, Spain, and the United Kingdom.

Interventions requested revolved around community engagement.

Despite reporting being in a state of waiting for resettlement, 8 out of 25 participants

expressed a desire to be involved in community activities that could mobilize social resources. They also requested help in developing certain skills, including how to deal with complicated administrative and legal procedures, and how to meaningfully occupy their time, as they linked inactivity to increased family conflict.

“The worst part is the inactivity, having nothing to do...I told the social worker once I would like to learn some activities I could do with my children, who are home all day, so they can do something instead of fighting all the time...I also asked her if I could come sometimes and help them, so I feel useful...I could also meet with other women in the same situation...” A 33-year-old mother of two

Theme 4. Lying is an adaptive mechanism in response to the humanitarian system.

During our interviews, participants told us about many strategies they used to “adapt” (تكيف), including changing their accent according to the zones they lived in, trying to avoid the Lebanese army check points, traveling with a child in the hopes of not being arrested, not wearing the “chahata شحاطة” (which are sandals commonly worn by Syrian workers), taking off the veil, and converting to Christianity in the hopes of getting access to church aid. These tactics of avoidance and adaptation are intended to help “keep a low profile”, according to Syrians. Changing their usual behaviors was reported along with changing narratives in order to correspond to the agencies’ perceived expectations. In fact, their relationship with the UNHCR was brought up without prompting, revealing itself as a pervasive concern, and tended to replace the discussion on MHPSS services.

The decisions of granting aid or resettlement by UNHCR are perceived as arbitrary and impenetrable.

We experienced many situations with Syrian participants that elucidated why they resorted to lying when dealing with any person who they thought might be linked to the UNHCR. One example is the case of a young displaced Syrian couple living with the wife’s

family. When we went to visit them, the brother and sister of the participant took us aside to tell us their stories: her sister's husband has been tortured, and he has just lost his job; her brother was beaten the year before by some Hezbollah men and was severely injured. They gave us their telephone numbers, and the number of their file at the UNHCR. Afterwards, we received a phone call from the participant. She apologized for their behavior because « half of what they told you is untrue. A few weeks ago, they were refused for resettlement and they hoped to change their situation through you». She wanted to make sure that their behavior did not have any negative consequences: she initially thought we had some authority and that we could inform the UNHCR.

The relationship with UNHCR and the Lebanese Government was repeatedly reported to be a source of confusion and anxiety for Syrians. They felt they did not know how to conform to the UNHCR expectations that were perceived as arbitrary and impenetrable. They described resorting to changing or hiding certain facts in order not to be excluded from aids or the possibility of being resettled. For example, it was only during our last home visit that we discovered that a father of five – who initially told us he was unemployed – worked as a waiter in a restaurant. He feared that if the UNHCR knew about that, they would cut his monthly aid. The UNHCR decision of granting aids or resettlement is perceived by Syrians as related to their capacity to prove their situation as a refugee. The medical certificate, the exposition of wounds, a display of morbidity: everything becomes a way of legitimating their requests. Refugees reported feelings of injustice facing the UNHCR “favoritism”: «we did the interview at the UN, they told us they were going to call again. Meanwhile, our neighbors were accepted to Canada. Why not us!» We repeatedly heard these sentiments from participants. The refugees' perceptions are summarized in Table 4:

Table 4. Emergent themes and sub-themes extracted from the interviews with refugees.

Themes	Sub-themes	Frequency
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1. Environmental and psychosocial stressors are the main causes of emotional distress.	-Environmental: lack of basic needs, poor housing, unemployment, lack of access to education and healthcare, perceived discrimination, movement restriction. - Psychosocial: Loss of role, social isolation. - Perceived lack of assistance from aid agencies.	All participants
2. Mental health symptoms are a normal and collective reaction to a build-up of pressure (ضغط)	- Symptoms of emotional distress: anger, frustration, hopelessness, inability to imagine a future, fear, fatigue, exhaustion, loss of dignity, chest pain and the metaphor of being strangled. - MHPSS services are perceived as a source of support and a potential link to UNHCR.	All participants
3. Resettlement is the only “true and definite” solution beyond the perceived need of psychosocial interventions.	- Resettlement is considered to be the only hope. - Interventions requested revolve around community engagement.	- All participants - 8 out of 25 (30%)
4. Lying is an adaptive mechanism in response to the humanitarian system.	- The decision of granting aid or resettlement by UNHCR is perceived as arbitrary and impenetrable.	20 out of 25 (80%)

4. Discussion

We aimed to understand the perspectives and experiences of professionals and Syrians involved in mental health services for refugees in Lebanon providing interventions at both level 3 (individual psychosocial support) and level 4 (clinical services) of the IASC pyramid ([IASC](#),

2007). Our findings reveal significant gaps in perceptions and needs that may hinder the therapeutic relationship, as well as insightful information about sources of misunderstandings between practitioners and refugees which carry implications for practice and policy.

Refugees view their distress as a normal collective reaction to adversity while professionals perceive it as symptoms of mental health disorders.

In line with a large body of evidence, both within the Syrian refugee setting (Alfadhli & Drury, 2018; Panter-Brick et al., 2018; Sim, Bowes, & Gardner, 2019; Sim, Fazel, Bowes, & Gardner, 2018; Wells et al., 2018, Wells, Steel, Abo-Hilal, Hassan, & Laws, 2016a; Wells et al., 2016b) and other refugee contexts (Barber et al., 2014; Eggerman & Panter-Brick, 2010; Jayawickreme et al., 2017; Li et al., 2016; Miller & Rasmussen, 2010; Ryan et al., 2008), our findings highlight that Syrians perceive economic, institutional and psychosocial stressors related to ongoing displacement as the main sources of emotional distress. The interaction of these stressors creates a build-up of “pressure ضغط”, resulting in mental health difficulties. The attribution of distress to external events - rather than internal dysfunction or disease - along with a shared sense of social suffering may explain the normalization of mental health problems and reduced stigma among Syrians in our study. Research focusing on a sample of Syrian informants in Jordan reached similar conclusions (Wells et al., 2016b), thus challenging the common notions that Arabic speaking cultures view mental health problems as indications of “craziness” or personal weakness (Hassan et al., 2015; Nasir & Al-Qutob, 2005) and that stigma is a barrier to seeking mental health services among refugees (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Saechao et al., 2012). Alternatively, this finding may be due to the Syrian refugees’ belief that emotional suffering is an inherent aspect of life; it is only the explicit psychological or psychiatric label that makes it shameful (Hassan et al., 2015). Similarly to other refugee settings (Shannon, Wieling, McCleary, & Becher, 2015), Syrians may view psychological distress as a continuum of symptoms embedded within a social,

political and economic context, rather than the presence/absence of a mental health disorder.

Professionals in our study tended to attribute the Syrians' emotional distress to an individual vulnerability and used medical language to describe the refugees' mental health problems. The psychiatric knowledge is validated through a medical legitimization "it is a disease like any other" and a universalizing process "depression is one of the most frequent illnesses in the world", with the aim of "educating" refugees on the nature of their problems and "convincing" them about the need of services. This translation of distress into medical terms seems justified within specialized clinical services focused on diagnosing and treating mental health disorders (level 4). However, diagnostic categories were also used by social workers at the non-specialized level of individual support (level 3) where the mhGAP seems widely used to screen for mental health conditions and refer accordingly to clinical services. We recognize that the use of diagnostic categories ensures continuity of care in case of referral, enables concise communication between practitioners and facilitates reporting to investors. Yet, our findings suggest a value in practitioners avoiding psychiatric labels when communicating with Syrian refugees suffering from mental health conditions and acknowledging the role of the crisis and displacement stressors in generating emotional distress. This acknowledgment might be more beneficial and allying, and replace the efforts in convincing refugees of mental health services. The presence of a psychiatric disorder according to diagnostic criteria and the need for clinical treatments should not invalidate refugees' own perception regarding the social nature of their emotional difficulties. Accordingly, practitioners should listen and validate individual and community stories of social injustice, lack of basic rights and poverty. The clinical process of diagnosing mental health conditions is clearly important, but the sole emphasis on checklists about symptoms of disorders might lack the political and social context for understanding them ([Shannon, Wieling, McCleary, & Becher, 2015](#)).

Culture as a source of misunderstanding

Professionals view the Syrian culture as an obstacle to overcome in order to discover the real underlying psychiatric disorder whose universality is hidden by culture. The Syrian culture is equated with “behavioral ineptitude” or a “defective value pattern” (Guntern, 1979) defined by illiteracy and lack of education. The labeling of behaviors deemed inexplicable by practitioners as “cultural” – such as the high birth rates - prevented them from understanding those behaviors from the refugees’ perspectives or identifying with the displacement experience (Sahab, Khoury, El Husseini, & Moro, 2018). This need to distance themselves from the Syrians – emphasized by the fact that they did not use the word “culture” in Arabic, the language they share with Syrians - may be a way to manage feelings of countertransference. Indeed, the term “refugee” in Lebanon may be negatively associated with the 15-year-Lebanese civil war and the Syrian occupation of the country until 2005, and may awaken mixed feelings and attitudes among Lebanese professionals (Geisser, 2013).

This finding has practical implications for program coordinators. Training sessions to develop awareness about the concept of culture as a dynamic system of meaning and practices which responds to changing environments (Kirmayer, 2006) might help avoid cultural stereotyping. The explanatory model approach of mental health and illness seems appropriate for a clinical setting as it explores the patients’ viewpoints concerning their own symptoms to reach an understanding of “how the social world affects and is affected by illness” alongside the expert knowledge (Kleinman & Benson, 2006). This model can be framed as an interview technique organized into a series of six steps detailed in Figure 4 and has been used efficiently to explore explanatory models of illness in other settings (Kleinman, 2007; Lee, Lee, Chiu, & Kleinman, 2005).

Figure 4. The explanatory model approach: a revised cultural formulation

(Adapted from Kleinman & Benson, 2006)

Step1: Asking about ethnic identity and determining whether it is an important part of the patient's sense of self.

Step 2: Evaluating what is at stake for the patient facing an episode of illness including relationships, material resources, social commitments, and life itself.

Step 3: Reconstructing the patient's illness narrative involving questions about one's explanatory model to understand the meaning of illness and distress.

Step 4: Considering the person's ongoing stresses and social supports in order to include interventions that improve life difficulties, alongside the clinical treatment.

Step 5: Examining culture in terms of its influence on clinical relationships. This step is about "training practitioners on critical self-reflection". In the context of our study, it needs to include reflexive exploration of countertransference attitudes related to the Lebanese collective political history with Syria.

Step 6: Taking into account the question of efficacy – namely, "does this intervention work in particular cases?"

Refugees emphasize resettlement as the definite solution to their problems while policymakers prioritize clinical short-term interventions.

Syrians in our study perceive UNHCR refugee resettlement as being the only definite solution to their social and mental health problems. This attitude suggests a lack of hope in other durable solutions to the refugee crisis, such as repatriation or full integration into Lebanese society. This finding can be contextualized in light of the political climate in Lebanon, where Lebanese authorities are exerting a continuous pressure on refugees to return to Syria, setting deadlines and threatening to demolish refugees shelters, while the situation in Syria remains unsafe (Geha & Talhouk, 2018). Further, the lack of a clearly defined and

consistent legal and administrative framework for Syrian refugees in Lebanon excludes any possibility of long-term integration into the host society (Geha & Talhouk, 2018; Nassar & Stel, 2019).

In this context, the resource-based model of migrant adaptation (Ryan, Dooley, & Benson, 2008) and the conservation of resources theory (Hobfoll, Stevens, & Zalta, 2015; Hobfoll, 2012) are useful for the interpretation of the emphasis placed by refugees on resettlement. According to the resource-based model, migrant adaptation to the host environment presents the individual with a series of potentially stressful demands. The capacity to manage these demands depends on access to a range of resources. These resources are divided into personal (mental and physical health), material (paid employment); social (social support) and cultural (Ryan, Dooley, & Benson, 2008). Our study reveals that refugees struggling with distress and attending mental health services perceive a total lack of availability of most of these resources, mainly material (financial strain); social (social isolation), and cultural (perceived discrimination). This forces reliance on their seemingly exhausted personal resources, leading to mental health problems. According to the conservation of resources theory, individuals will not be motivated to pursue new resources if they feel it will jeopardize their already tenuous ones (Hobfoll, Stevens, & Zalta, 2015; Hobfoll, 2012). Therefore, their adaptive efforts will be concentrated on leaving this poorly-resourced environment and conserving their personal resources rather than unsuccessfully trying to adapt. In this context, a clinical diagnosis of adjustment disorder or the incapacity to adapt may be understood as the result of an adverse environment that seems structurally constituted to impede all adaptation efforts.

Yet, some participants expressed the need for community interventions centered on skill building and social engagement. In a political environment marked by uncertainty, these interventions may help access resources and withstand losses, preventing the “build-up of

pressure” that leads to mental health difficulties and specialized services. Policymakers in our study, however, emphasize the importance in the MOPH policies of short-term clinical interventions as a response to refugees’ distress. This focus on clinical interventions is in line with official recommendations published by the UNHCR (El Chammay, Kheir, & Alaoui, 2013) and the MOPH (Kheir, Gibson, Kik, Hajal, & El Chammay, 2015) regarding MHPSS services for refugees. These recommendations include training non-specialized staff (such as social workers) on the mhGAP in order to be able to detect mental health conditions, while training specialized staff on IPT, EMDR, and/or Trauma Focused Therapy (Karam et al., 2016; Kheir, Gibson, Kik, Hajal, & El Chammay, 2015) which are short-term, highly specialized forms of therapy. There are no recommendations however in the MOPH/UNHCR publications on the types of interventions to be included at the level of psychosocial support (level 3), even though half of the MHPSS services for refugees in Lebanon fall within this level as shown in Figure1. Policymakers and program coordinators in our study explained this focus on clinical services by the lack of evidence for psychosocial interventions in refugee settings and the lack of consensus over psychosocial activity, whereas brief, structured specialized therapies have been studied in conflict-affected settings (Betancourt et al., 2014; Bolton et al., 2003; Rahman et al., 2016). Without denying the importance of clinical interventions for individuals with mental illnesses, we note that international consensus recommends that mental health interventions in a humanitarian setting should also aim at strengthening communities and individuals by providing emotional support, reestablishing a sense of safety and organizing social networks (IASC, 2007; Silove, 2011; Quosh, 2013; Wells et al., 2018). Moreover, emerging evidence validates the necessity of psychosocial interventions that respond to refugees needs through structured group-based activities which may go alongside clinical interventions to promote social support (Panter-Brick et al., 2018; Sim, Bowes, & Gardner, 2019).

Additionally, policymakers justified the choice of short-term interventions by defining the Syrian situation as an “acute emergency crisis”. However, the Syrian crisis has been ongoing for over seven years and should be considered a protracted crisis. This position seems to reflect the Lebanese Government’s wider policy of “institutional ambiguity” in response to the Syrian refugee crisis (Nassar & Stel, 2019). In the context of limited resources and the country’s dysfunctional political system, the maintenance of a temporary and emergency status allows the government to abstain from establishing long-term strategies for refugees (Nassar & Stel, 2019).

Practitioners consider refugees’ lies as manipulative while refugees resort to lying as an adaptive mechanism.

The significance of the relationship between refugees and the humanitarian system as well as the phenomenon of lying emerged inductively from the datasets, as the data underlying our analysis were not initially gathered to highlight these issues. The lying phenomenon presented itself as a defining feature of the Syrians’ daily life. In an attempt to survive adversity and perceived discrimination, Syrian participants feel forced to adopt behaviors and narratives that are considered in line with the agencies’ perceived expectations, even if they do not conform to their usual self. Changing narratives allows refugees to legitimate their request to the authorities, yet institutions expect them to express a truthful and credible narration of self. The MHPSS services are affected by this issue since Syrians perceive them as an agency that can advocate on their behalf to the UNHCR, while MHPSS practitioners feel manipulated when refugees lie to them. This dynamic threatens the therapeutic alliance by generating doubt and mistrust.

Roberto Beneduce suggested the concept of the «moral economy of lying», while exploring the narrative strategies used by migrants to face the bureaucratic violence of the asylum procedure. This concept provides «analytic pathways to understand the meaning of

behaviors or narratives that are often trivialized as being simple tactics aimed at gaining immediate advantages» (Beneduce, 2015). Even though it does not necessarily apply to all refugee settings, this concept helps explain the Syrian refugees' reality and the attitude they adopt toward institutions: lying discloses a field of power relations, the humanitarian space, in which the refugee is embedded. It appears to be a result of the extreme dependence of the refugees on the aid, which forces them to play with their representations of self. In unstable environments where resources are unpredictable, developing a set of behavioral and conversational norms with agencies might allow refugees to deal with the perceived arbitrary procedures of the UNHCR and/or the constant fear of random arrest by the Lebanese Government. Lying may have an adaptive function in response to the humanitarian and governmental system, where refugees are rational actors who adjust their behaviors and narratives based on assessments of environmental risks and benefits, in line with the resource-based model and the conservation of resources theory (Ryan, Dooley, & Benson, 2008; Sim, Fazel, Bowes, & Gardner, 2018; Hobfoll, 2012). In our study, strategies employed by Syrians to adapt to their resource-constrained environment involved changing behaviors and stories to be eligible for aids and resettlement or avoid arrest. These strategies allowed for the participants' survival but generated distress as they feared being discovered.

Finally, the lying phenomenon matches Gambetta's theory of trust (Gambetta, 1998) and more specifically the issue of trust or mistrust in relation to the "refugee's experience" (Hynes, 2003). If trust is understood as being able to have confidence in a person or a system, lying reveals that refugees have a fundamental lack of trust in the capacities of the humanitarian system and/or the Lebanese Government to help them. This can be the result of the structural violence they are exposed to and the institutional ambiguity they are embedded in (Parkinson & Behrouzan, 2015; Nassar & Stel, 2019). The refugee "mistrusts and is mistrusted" (Hynes, 2003), as the aid agencies continuously attempt to define their eligibility for aids or

resettlement dependent upon target or vulnerable group definitions. At the level of the practitioner-refugee relationship, this has significant repercussions, as reciprocal trust is fundamental to building a therapeutic alliance ([Lambert, 2013](#)), and establishes a moral dimension to healing that is related to, but distinct from, the medical aspect of treating a mental health condition ([Kleinman, 2007](#)).

Limitations

Our sample did not include Syrian refugees from all regions in Lebanon and was smaller than the sample of professionals. This was due to the lack of access granted by NGOs to refugees, whereas all NGOs allowed practitioners to be interviewed. Nonetheless, the regions we sampled from, Bekaa and Beirut, host the largest number of Syrian refugees in the country ([UNHCR, 2019](#)). We did not include individuals suffering from severe and chronic mental health conditions (e.g., schizophrenia, bipolar disorder) and the majority of our participants were women. Our sample of professionals does not give a comprehensive view of all MHPSS services available to refugees as it focused on NGOs providing both interventions at level 3 (individual psychosocial support) and level 4 (clinical services) of the IASC pyramid. There are many other organizations providing psychosocial support without clinical services, as well as NGOs providing services at lower levels of the pyramid, and the coordination between all these actors within the IASC framework should be studied. These limitations emphasize the need for further qualitative research that purposefully samples a larger and more diverse population.

5. Implications for policy

Our findings, which should be interpreted in light of the small sample size and the restriction to individual based services at levels 3 and 4 of the IASC pyramid, generated some hypotheses that merit further investigations to inform policy and apply recommendations:

- Raising awareness among practitioners on the negative impact of psychiatric labeling while

communicating with refugees seems warranted, especially at the level of psychosocial support services.

- Incorporating the explanatory model approach of mental health and illness in the psychosocial and clinical interview might help avoid cultural stereotyping while clarifying the meaning assigned by refugees to mental health symptoms within a social context.

- Understanding the refugee lying phenomenon and potential countertransference attitudes through reflexive trainings and peer-to-peer supervision might help strengthen the therapeutic alliance and avoid misunderstandings and distrust.

- There might be a need for clinical services to be complemented by psychosocial and community programs rather than function independently. Undoubtedly, interventions that target social suffering, cannot replace clinical interventions for individuals with mental illnesses; approaching refugees' distress must rely on both types of interventions, therefore capturing suffering as both shared and unique, rather than an individual or isolated experience. The official recognition and implementation by the Lebanese MOPH of sustainable community and psychosocial programs would help bridge this gap, along with a better coordination between all MHPSS actors of the IASC pyramid.

6. Conclusion

The triangulation of findings from both the refugees' and professionals' interviews identified the importance of acknowledging structural and social stressors, avoiding labels and combining clinical services with psychosocial and community-based interventions. Importantly, the therapeutic alliance between Lebanese practitioners and Syrian refugees is challenged at times by the professionals' perceptions of the Syrian culture and the mistrust generated by the "lying" of refugees. This lying seems to be a self-protective mechanism in response to the structural violence faced by refugees within the larger humanitarian bureaucracy and the Lebanese State apparatuses and will persist so long as humanitarian

practices do not integrate the experience of everyday refugee life. Finally, our study shows the importance of establishing trust while doing research with refugees, to mitigate the impact of inequalities (Hynes, 2003). Syrian participants broached the lying phenomenon only once they were sure we had no connection to aid agencies. This further emphasizes the need for participant centered research to allow an in-depth understanding of the refugees' struggle for survival.

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Declaration of conflicting interests

The Authors declare that there is no conflict of interest.

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• Abbreviations

EMDR: Eye-Movement Desensitization Reprocessing Therapy

IASC: Inter-Agency Standing Committee

IPT: Interpersonal Therapy

mhGAP: Mental Health Gap Action Program

MHPSS: Mental Health and Psychosocial Support

NGOs: Non-Governmental Organizations

PTSD: Post-traumatic Stress Disorder

UNHCR: United Nations High Commissioner for Refugees

MOPH: Ministry of Public Health

WHO: World Health Organization